ALTERNATIVE SLEEP POSITION WAIVER
Physician Recommendation

Child's Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ Email: _____

The child's primary care physician must complete the following section.

Name of Primary Care Physician: _____

Name of Practice: _____

Address: _____

Phone: _____ Pager: _____ Fax: _____

Email: _____

The NC Child Care Law requires child care facilities to place all infants on their backs to sleep. At the advice of the child's physician, the center may be authorized to use an alternative sleep position for the child due to medical reasons.

The above named child has the following medical condition that necessitates an alternative sleep position:

_____

Please describe the appropriate sleep position for the above named child:

_____

Effective Dates of Waiver: **from** _____/_____/_____ **to** _____/_____/_____

Physician's Signature: _____ Date: _____

"I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that I been provided with information concerning SIDS. I further authorize the child care facility and its employees to place my child in an alternative sleep position, at the recommendation of my child's primary care physician, as described above."

Parent/Guardian Signature: _____ Date: _____

An authorized official with the child care facility must complete the following section.

Name of Child Care Facility: _____ ID #: _____

Facility Representative's Signature: _____ Date: _____

NC DCD *September 2003*